pounds in two months, coincident with this disturbance of digestion. We expected to find much trouble with the stomach so a test meal was taken with the following result: Total acidity 20, no free HCl, only 4 parts combined HCl. A few days subsequently a second test was made which corresponded almost exactly with the first. Neither the stomach contents nor the feces showed occult blood, and a diagnosis such as cancer or ulcer had to be abandoned. There was no dilatation of the stomach except secondarily. We next found a large tumor mass extending across the upper abdomen, descending freely on deep inspiration, rounded, smooth, only moderately tender. By percussion it was possible to make out that this mass was the lower border of the liver. The spleen was also enlarged and palpable. The man had decidedly enlarged liver and spleen, and urine examination showed that he had also a chronic nephritis. The problem then became to find what could be back of these various pathological findings. Clinically the man had hypertrophic cirrhosis and chronic nephritis; but his history was clear as regards any of the usual causes for cirrhosis as he had practically never used alcohol. He was a hard working man, leading a regular life and there was no trouble in the heart. Dr. Oliver found in this case also a very positive Wasserman reaction; and we came to the conclusion that the cirrhosis was luetic in character. The patient was then placed upon syphilitic treatment under which he has so very greatly improved that the gastric condition is no longer in evidence, the liver and spleen have reduced in size, he feels well, and the temperature has become normal. I brought this patient for presentation because the case is a little out of the ordinary. It is interesting because we are finding more and more evidence of visceral lues, where formerly we did not know how to determine such cases without the Wasserman reaction.

Examination of patient.

Discussion.—George H. Evans: I would like to ask Dr. Cheney in reference to the diagnosis of the case of pleural effusion, whether or not a guinea pig had been injected with the pleural fluid. I would also like to ask him, assuming that the patient was a tuberculosis-free individual, on what ground he would assume that the first dose of tuberculin would so sensitize the patient that a second dose for diagnostic purposes would be useless.

Wm. Fitch Cheney: With regard to the guinea pig injection, we did not get one because the first time the fluid was spilled before we could get it into the guinea pig, and the second time we tried we could not find any fluid. I did not mean to infer that one milligram of the tuberculin would interfere with subsequent subcutaneous reaction, only it might be sufficient to sensitize the conjunctiva or the skin. If following this milligram injected subcutaneously we had obtained an ophthalmic reaction or a Von Pirquet reaction, would we have had the right to assume that the man had a tuberculosis? That was the point about which we hesitated.

Presentation of a Medical Case.

By H. D'ARCY POWER, M. D., San Francisco.

This patient came into my service at the Polyclinic when I took charge in April and I present him to you because, like Dr. Cheney's case, it brings out some of the difficulties of diagnosis. The case in point is that of a young man who, at the end of '08, four months after the contraction of a chancre which was followed by secondaries, was suddenly seized by a paraplegia affecting both the arms and legs, together with the loss of speech, lasting three weeks, and a disability of speech which lasted three months or more. Upon his recovery of sufficient motion of the arms and feet to make use of them, the arms showed marked loss of co-ordination, he was unable to carry anything to his mouth without spilling it; as the power in the feet was recovered, the gait was markedly ataxic and spastic, and an ataxia rather of the cerebellar form. Things continued so for many months; there was gradual improvement, until he was admitted to the City and County Hospital and was there for some time before I saw him. He was the subject of a great deal of discussion as to the nature of his case. The fundus of the eye, examined at the end of '09, showed hyperemia but no other changes. At the time that I saw him the eyes showed nystagmatoid movements, he had cerebellar-ataxic and spastic gait, great increase of all deep reflexes, loss of superficial reflexes, including the abdominal, had very, very marked hesitation in his speech of the semi-scanning character; some little of that has remained until the present time. The eye in April showed no true nystagmus. He had lost in the beginning quite considerably in weight and had lost the power over his bladder and rectum for two or three months. The question arose as to what we were dealing with —some seemed to think it was a case of cerebrospinal syphilis; the onset of the symptoms within four months of the chancre was quite early, almost too early for the development of symptoms of this character, moreover the clinical picture was not that of cerebral lues. Hysteria was suggested but the presence of the Babinski reflex, and the history of bladder and rectal disturbance is exclusive; furthermore the cerebro-spinal fluid was examined, with a negative result; there was no lymphocytosis. Noguchi also negative. To me it seems that we are not dealing with a cerebrospinal syphilis but an early and atypical disseminated sclerosis. In its favor is the paraplegic onset, with rapid recovery of the arms, the condition of both deep and superficial reflexes, especially the loss of the abdominal, the typical gait, the history of intentional inco-ordination of the hands, the eye symptoms with the optic hyperemia, the nystagmatoid movements; in fact a diagnosis by exclusion narrows the issue to lues or disseminated sclerosis, with in my judgment the balance in favor of disseminated sclerosis.

Presentation of a Case of Multiple Sclerosis.

By LOUIS D. MEAD, M. D., San Francisco.

This patient is 64 years of age, was a laborer by occupation and a native of Norway. He knows nothing of his family history.

Past History: Had measles when 10 years of age, drank a great deal of brandy as a young man, denies venereal history, no history of acute infectious disease of any kind. In 1882 went to work in the Hawaiian Islands on a sugar plantation. The work was heavy and most of the time he was compelled to wade up to his knees in irrigation ditches. After a period of one year of such labor the present trouble began, i. e. at the age of 37.

Present illness: This commenced insidiously, with weakness in the lower limbs, unaccompanied by numbness or stiffness. His gait became unsteady on account of the gradually increasing weakness, was compelled to do lighter work. At the expiration of four years was compelled to leave the Islands and he sought relief at the City and County Hospital, where he remained for six months. At this time he complained of a certain amount of pain in the legs and across the lumbar region. He was able to walk with the aid of one cane. While in the hospital the trouble increased rapidly and he was compelled to use two canes, and later crutches. Tremor developed in both hands, which was intensified upon attempting to feed himself; no convulsions, but there

were periods lasting several hours at a time when he was in semi-conscious condition. During this time he suffered from incontinence of urine and feces, which has since disappeared; no disturbance of speech.

After six months he was transferred to the Alms House. In Dec., 1907, he was readmitted to the City and County Hospital. He has been compelled to use a wheel chair since 1888. He complains of no pain except in the legs when occasionally they are attacked by convulsive movements. A number of years ago there was blurred vision, but now the eyesight is excellent. There is weakness in the lumbar muscles; hearing is good; no girdle sensation, bladder or rectal symptoms.

Physical examination: Fairly well nourished, expression alert, speech is slow, halting and in a monotone, i. e. fairly well marked scanning speech; pupils are small, equal and react sluggishly to light and accommodation. Nystagmus is not marked, eye ground normal, no involvement of the cranial nerves. Upper extremeties; there is a coarse, wavy tremor of both upper extremities at the rapidity of from 5 to 7 per second, the motion is lateral in the right hand and vertical in the left hand, especially in the index, middle and ring fingers. Muscular power fairly good. Lower extremities; there is a flaccid paralysis of both extremities, double drop foot, the only motion remaining is a slight power of extension of the leg on the thigh. Reflexes; both superficial and deep entirely abolished. Very little atrophy or vasomotor disturbance.

As to the clinical diagnosis in this case, I feel that we are justified in considering it an advanced case of multiple sclerosis. As a rule this disease begins between the tenth and thirty-first year, but no age is exempt, in the present instance the onset was at 37 years of age. Multiple sclerosis is not an inherited disease, neither is this; it has no relation to syphilis, nor is there any history of syphilis in this case. It usually follows cold, trauma or an acute infectious disease; in this case we have the well marked history of exposure. Multiple sclerosis is gradual in onset, usually beginning with numbness or weakness in the legs, spastic or cerebellar gait, with marked increased knee jerks and Babinski signs. The present case does not conform to these symptoms; it has gone beyond the stage of spasticity and is followed by the flaccid paralysis noted. The intention tremor is one of the characteristic symptoms of the disease, as is also the scanning speech. The tremor of the head somewhat similar to senile tremor is often noted in cases of multiple sclerosis, but this condition is not present here. Nystagmus is usually an early and persistent symptom, occurring in about 75 per cent of the cases; here the nystagmus is slight and can be practically disregarded. Temporary attacks of blindness are often noted in the early stages of this disease; in the present case attacks of blurred vision were present. Optic atrophy is frequently noted, occurring, according to Utthoff, in about 52 per cent. of the cases; the symptom is absent in this case. Paresthesias are frequently noted while anesthesia is never present, and similar conditions are noted in this case.

From the presence of the marked intention tremor, the slight nystagmus and the fairly characteristic scanning speech, and as we are able to exclude practically all of the other nervous diseases, I feel that we are justified in considering this clinically a case of multiple sclerosis.

Discussion.—H. C. McClenahan. Of course, in the discussion of the syndrone, that we generally call multiple sclerosis, much depends upon our pathological conception of the clinical picture we include in multiple sclerosis. Strümpel says that: "When we find a symptom complex, that we are unable to fit to any other disease of the central nervous system, it is a good plan to call it multiple sclerosis." I will state, however, that I have never accused multiple sclerosis of a flaccid paralysis of the lower limbs. It is new to me, and the man has apparently an Argyle Robinson pupil, at least the pupils seem sluggish to light.

The case Dr. Power has presented I saw at the City and County Hospital, and I thought at that time that the man was suffering from cerebro-spinal syphilis, and for the reason that the symptoms came on very abruptly, which is not so characteristic of multiple sclerosis, in our clinical conception of it. It is an insidious disease which comes on rather intermittently, instead of gradually or by sudden attacks. The pathological condition of multiple sclerosis of course cannot be diagnosed clinically, and whether this case is due to syphilis or not is the question. Owing to the abruptness of the onset and the great improvement, I think the case has many symptoms of cerebro-spinal syphilis.

Meeting of November 8, 1910.

The Etiological Significance of Persistent Affective States in Neurasthenia.

By G. V. HAMILTON, M. D., Montecito.

The current generalization that ascribes neurasthenia to mental and physical strain must at least be qualified with reference to the fact that a considerable percentage of cases give histories of having weathered without damage the major griefs, worries, responsibilities and activity-demands of life, only to have developed, after a considerable interval, and in the midst of an apparently comfortable situation, the characteristic symptoms of neurasthenia. It must be admitted, therefore, that if mental and physical strain are causes of this disorder, their etiological value often bears no consistent relation, in a given individual, to their intensity. Unless one be prepared to admit that the etiology of neurasthenia is wholly implicit in the make-up of its victims, it follows that progress in our understanding of the disorder demands, first of all, ever more careful analyses of the situations in which it arises.

The present communication is an attempt to point out an element which is common to a great diversity of concrete situations that appear in neurasthenic histories, and to assign to this element a value in terms of an interesting psycho-physical mechanism. The presentation of a typical case will serve to illustrate the intention of the discussion that follows:

Mrs. X, age 31 years, American, widow. Illustrator. Family and early personal history negative. The patient was a physically robust child, and presented no nervous traits that can be recalled. Until the onset of the present illness she habitually entered into the natural interests and activities of her life with great zest, and was quite free from marked fluctuations of mood, self-examination, dreaminess, seclusiveness, irritability, etc. Her ultimate breakdown was a source of much surprise to her friends, who had never thought of her as having "nerves."

She was married at 20, and a year later bore a child which now, at 10 years, presents a good history with respect to both mental and physical development. The patient's married life was happy and uneventful until its termination six years ago by the death of her husband. She bore his loss with great fortitude, and at once set about to support her child and herself, to which end she made a practical application of her artistic ability. The griefs, worries, disappointments and hard work incident to this period of her life brought no discoverable impairment.